Fill in this information to identify the case:

Debtor Name James Samatas

United States Bankruptcy Court for the: Northern District of Illinois (State)

Case number: 20-17355

Official Form 426

Periodic Report Regarding Value, Operations, and Profitability of Entities in Which the Debtor's Estate Holds a Substantial or Controlling Interest

12/17

This is the *Periodic Report* as of 12/31/18 on the value, operations, and profitability of those entities in which a Debtor holds, or two or more Debtors collectively hold, a substantial or controlling interest (a "Controlled Non-Debtor Entity"), as required by Bankruptcy Rule 2015.3. For purposes of this form, "Debtor" shall include the estate of such Debtor.

[Name of Debtor] holds a substantial or controlling interest in the following entities:

Name of Controlled Non-Debtor Entity	Interest of the Debtor	Tab #
Lexington Healthcare Center of Lombard, Inc.	33.33%	

This *Periodic Report* contains separate reports (*Entity Reports*) on the value, operations, and profitability of each Controlled Non-Debtor Entity.

Each *Entity Report* consists of five exhibits.

Exhibit A contains the most recently available: balance sheet, statement of income (*loss*), statement of cash flows, and a statement of changes in shareholders' or partners' equity (*deficit*) for the period covered by the *Entity Report*, along with summarized footnotes.

Exhibit B describes the Controlled Non-Debtor Entity's business operations.

Exhibit C describes claims between the Controlled Non-Debtor Entity and any other Controlled Non-Debtor Entity.

Exhibit D describes how federal, state or local taxes, and any tax attributes, refunds, or other benefits, have been allocated between or among the Controlled Non-Debtor Entity and any Debtor or any other Controlled Non-Debtor Entity and includes a copy of each tax sharing or tax allocation agreement to which the Controlled Non-Debtor Entity is a party with any other Controlled Non-Debtor Entity.

Exhibit E describes any payment, by the Controlled Non-Debtor Entity, of any claims, administrative expenses or professional fees that have been or could be asserted against any Debtor, or the incurrence of any obligation to make such payments, together with the reason for the entity's payment thereof or incurrence of any obligation with respect thereto.

This *Periodic Report* must be signed by a representative of the trustee or debtor in possession.

Debtor Name James Samatas Case number 20-17355

The undersigned, having reviewed the *Entity Reports* for each Controlled Non-Debtor Entity, and being familiar with the Debtor's financial affairs, verifies under the penalty of perjury that to the best of his or her knowledge, (i) this *Periodic Report* and the attached *Entity Reports* are complete, accurate, and truthful to the best of his or her knowledge, and (ii) the Debtor did not cause the creation of any entity with actual deliberate intent to evade the requirements of Bankruptcy Rule 2015.3

For non-individual Debtors:

✘ _____
Signature of Authorized Individual

James Samatas
Printed name of Authorized Individual

Date January 23, 2021
MM / DD / YYYY

For individual Debtors:

✘ _____
Signature of Debtor 1

_____
Printed name of Debtor 1

Date _____
MM / DD / YYYY

✘ _____
Signature of Debtor 2

_____
Printed name of Debtor 2

Date _____
MM / DD / YYYY

Debtor Name James Samatas Case number 20-17355

Exhibit A: Financial Statements for Lexington Healthcare Center of Lombard, Inc.

See attached State of Illinois Department of Healthcare and Family Financial and Statistical Report (Cost Report) for Long-Term Care. (Fiscal Year 2018).

Debtor Name James Samatas Case number 20-17355

Exhibit A-1: Balance Sheet for Lexington Healthcare Center of Lombard, Inc.

[Provide a balance sheet dated as of the end of the most recent 3-month period of the current fiscal year and as of the end of the preceding fiscal year.

Describe the source of this information.]

See attached State of Illinois Department of Healthcare and Family Financial and Statistical Report (Cost Report) for Long-Term Care. (Fiscal Year 2018).

Debtor Name James Samatas Case number 20-17355

Exhibit A-2: Statement of Income (*Loss*) for Lexington Healthcare Center of Lombard, Inc. for period ending 12/31/2018

[Provide a statement of income (*loss*) for the following periods:

(i) For the initial report:

a. the period between the end of the preceding fiscal year and the end of the most recent 3-month period of the current fiscal year; and

b. the prior fiscal year.

(ii) For subsequent reports, since the closing date of the last report.

Describe the source of this information.]

See attached State of Illinois Department of Healthcare and Family Financial and Statistical Report (Cost Report) for Long-Term Care. (Fiscal Year 2018).

Debtor Name James Samatas Case number 20-17355

Exhibit A-3: Statement of Cash Flows for Lexington Healthcare Center of Lombard, Inc. for period ending 12/31/2018

[Provide a statement of changes in cash position for the following periods:

(i) For the initial report:

a. the period between the end of the preceding fiscal year and the end of the most recent 3-month period of the current fiscal year; and

b. the prior fiscal year.

(ii) For subsequent reports, since the closing date of the last report.

Describe the source of this information.]

See attached State of Illinois Department of Healthcare and Family Financial and Statistical Report (Cost Report) for Long-Term Care. (Fiscal Year 2018).

Debtor Name James Samatas Case number 20-17355

Exhibit A-4: Statement of Changes in Shareholders'/Partners' Equity (*Deficit*) for Lexington Healthcare Center of Lombard, Inc. for period ending 12/31/2018

[Provide a statement of changes in shareholders'/partners equity (*deficit*) for the following periods:

(i) For the initial report:

a. the period between the end of the preceding fiscal year and the end of the most recent 3-month period of the current fiscal year; and

b. the prior fiscal year.

(ii) For subsequent reports, since the closing date of the last report.

Describe the source of this information.]

None

Debtor Name James Samatas Case number 20-17355

Exhibit B: Description of Operations for Lexington Healthcare Center of Lombard, Inc.

[Describe the nature and extent of the Debtor's interest in the Controlled Non-Debtor Entity.

Describe the business conducted and intended to be conducted by the Controlled Non-Debtor Entity, focusing on the entity's dominant business segments.

Describe the source of this information.]

Lexington Center of Lombard, Inc. is an Illinois corporation engaged in the ownership and operation of a nursing home. The Illinois Department of Public Health License No. is 0028860. The Debtor only has in his possession the financial information filed with the State of Illinois for the period of January 1, 2018 to December 31, 2018. The Debtor will supplement this information in the future.

See attached State of Illinois Department of Healthcare and Family Financial and Statistical Report (Cost Report) for Long-Term Care. (Fiscal Year 2018).

Debtor Name James Samatas Case number 20-17355

Exhibit C: Description of Intercompany Claims

[List and describe the Controlled Non-Debtor Entity's claims against any other Controlled Non-Debtor Entity, together with the basis for such claims and whether each claim is contingent, unliquidated or disputed.

Describe the source of this information.]

None

Debtor Name James Samatas Case number 20-17355

Exhibit D: Allocation of Tax Liabilities and Assets

[Describe how income, losses, tax payments, tax refunds, or other tax attributes relating to federal, state, or local taxes have been allocated between or among the Controlled Non-Debtor Entity and one or more other Controlled Non-Debtor Entities.

Include a copy of each tax sharing or tax allocation agreement to which the entity is a party with any other Controlled Non-Debtor Entity.

Describe the source of this information.]

There are no such agreements

Debtor Name James Samatas Case number 20-17355

Exhibit E: Description of Controlled Non-Debtor Entity's payments of Administrative Expenses, or Professional Fees otherwise payable by a Debtor

[Describe any payment made, or obligations incurred (or claims purchased), by the Controlled Non-Debtor Entity in connection with any claims, administrative expenses, or professional fees that have been or could be asserted against any Debtor.

Describe the source of this information.]

No such payments

FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0028860

Facility Name: Lexington Health Care Center of Lombard

Address: 2100 S. Finley Road (Number) Lombard (City) 60148 (Zip Code)

County: Dupage

Telephone Number: (630) 495-4000 **Fax #** (630) 495-2809

HFS ID Number:

Date of Initial License for Current Owners: 10/09/84

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/18 to 12/31/18 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) RSM US LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	224	Skilled (SNF)	224	81,760	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	224	TOTALS	224	81,760	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			6,875	6,875	8
9	SNF/PED					9
10	ICF	29,825	11,936	3,737	45,498	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,825	11,936	10,612	52,373	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.06%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/9/84

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New Construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 214 and days of care provided 5,006

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	425,614	27,072	11,275	463,961		463,961	-	463,961			1
2	Food Purchase		348,638		348,638		348,638	-	348,638			2
3	Housekeeping	444,779	37,094	-	481,873		481,873	306	482,179			3
4	Laundry	-	19,183	-	19,183		19,183	-	19,183			4
5	Heat and Other Utilities			268,091	268,091		268,091	8,705	276,796			5
6	Maintenance	43,261	-	164,632	207,893		207,893	141,965	349,858			6
7	Other (specify):* Mgmt Co.-Allocated E	-	-	-				14,256	14,256			7
8	TOTAL General Services	913,654	431,987	443,998	1,789,639		1,789,639	165,232	1,954,871			8
	B. Health Care and Programs											
9	Medical Director	-	-	48,550	48,550		48,550	-	48,550			9
10	Nursing and Medical Records	4,378,479	322,646	601,830	5,302,955		5,302,955	26,044	5,328,999			10
10a	Therapy	-	-	-				-				10a
11	Activities	184,110	13,467	5,177	202,754		202,754	-	202,754			11
12	Social Services	187,995	-	4,611	192,606		192,606	-	192,606			12
13	CNA Training	-	-	-				-				13
14	Program Transportation	-	-	-				-				14
15	Other (specify):* Mgmt Co.-Allocated E	-	-	-				2,728	2,728			15
16	TOTAL Health Care and Programs	4,750,584	336,113	660,168	5,746,865		5,746,865	28,772	5,775,637			16
	C. General Administration											
17	Administrative	157,731	-	1,532,340	1,690,071		1,690,071	(1,510,645)	179,426			17
18	Directors Fees			-				-				18
19	Professional Services			211,283	211,283		211,283	73,591	284,874			19
20	Dues, Fees, Subscriptions & Promotions			23,703	23,703		23,703	14,692	38,395			20
21	Clerical & General Office Expenses	198,646	21,848	74,319	294,813		294,813	1,026,323	1,321,136			21
22	Employee Benefits & Payroll Taxes			892,705	892,705		892,705	-	892,705			22
23	Inservice Training & Education			6,642	6,642		6,642	595	7,237			23
24	Travel and Seminar			-				772	772			24
25	Other Admin. Staff Transportation		-	1,171	1,171		1,171	17,146	18,317			25
26	Insurance-Prop.Liab.Malpractice			579,996	579,996		579,996	3,104	583,100			26
27	Other (specify):* Mgmt Co.-Allocated E	-	-	-				108,830	108,830			27
28	TOTAL General Administration	356,377	21,848	3,322,159	3,700,384		3,700,384	(265,592)	3,434,792			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,020,615	789,948	4,426,325	11,236,888		11,236,888	(71,588)	11,165,300			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard #0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			150,776	150,776		150,776	253,108	403,884			30
31	Amortization of Pre-Op. & Org.			-				-				31
32	Interest			26,786	26,786		26,786	94,286	121,072			32
33	Real Estate Taxes			-				200,296	200,296			33
34	Rent-Facility & Grounds			729,135	729,135		729,135	(724,474)	4,661			34
35	Rent-Equipment & Vehicles			56,438	56,438		56,438	2,017	58,455			35
36	Other (specify):*			-				-				36
37	**TOTAL Ownership**			963,135	963,135		963,135	(174,767)	788,368			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-				-				38
39	Ancillary Service Centers	-	204,991	930,822	1,135,813		1,135,813	-	1,135,813			39
40	Barber and Beauty Shops	-	-	14,066	14,066		14,066	-	14,066			40
41	Coffee and Gift Shops	-	-	-				-				41
42	Provider Participation Fee			409,978	409,978		409,978	-	409,978			42
43	Other (specify):* Non-Allowable Cos	(16,145)	-	388,389	372,244		372,244	(372,244)				43
44	**TOTAL Special Cost Centers**	(16,145)	204,991	1,743,255	1,932,101		1,932,101	(372,244)	1,559,857			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,004,470	994,939	7,132,715	14,132,124		14,132,124	(618,599)	13,513,525			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(15,348)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	61,765	30		9
10	Interest and Other Investment Income	(153,576)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(12,138)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(39,731)	43		18
19	Entertainment				19
20	Contributions	(120)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(270,657)	43		24
25	Fund Raising, Advertising and Promotional	(25,742)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,686)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(163,686)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (622,919)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	4,320		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 4,320		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (618,599)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Lexington Health Care Center of Lombard

ID# 0028860

Report Period Beginning: 1/1/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	$ (1,165)	43	1
2	Labs - Part A	(10,368)	43	2
3	X-Rays - Part A	(7,656)	43	3
4	Marketing Salary	16,145	43	4
5	Trust Fees	(80)	43	5
6	State Replacement Tax	(7,274)	43	6
7	Collections	(37,568)	19	7
8	Out of Period Legal	(97)	19	8
9	Non Allowable Dues	(2,673)	20	9
10	Education & Seminar Marketing	(1,778)	43	10
11	Misc Income	(41)	21	11
12	Gain/Loss on disposal of mortgage costs	(108,834)	43	12
13	Non-Allowable Finance Charge	(2,297)	32	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(163,686)		49

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Fees	$	Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	$ 200	$ 200	1
2	V	30	Depreciation Expense		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	165,602	165,602	2
3	V	32	Amortization of Mortgage Cost		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	57,494	57,494	3
4	V	32	Interest	259,659	Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	433,998	174,339	4
5	V	33	Property Tax		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	193,449	193,449	5
6	V	34	Rent	729,135	Lexington Health Care Systems of Lombard Ltd. Ptsp.	**		(729,135)	6
7	V	43	Office Supplies		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	93	93	7
8	V	43	(Gain)/Loss - disposal of assets		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	108,834	108,834	8
9	V	21	Miscellaneous Expense		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	3	3	9
10	V	43	State Replacement tax		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	7,274	7,274	10
11	V	43	Trust fees		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	80	80	11
12	V				** The owners of Lexington Health Care Center of Lombard, Inc. own				12
13	V				100% of Lexington Health Care Systems of Lombard Limted Partnership.				13
14	Total			$ 988,794			$ 967,027	$ * (21,767)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 306	$ 306	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	7,926	7,926	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	210	210	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	569	569	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	133,369	133,369	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	8,250	8,250	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	346	346	21
22	V	7	Management allocation - employee benefits		Royal Management Corp.	**	14,256	14,256	22
23	V	10	Medical consultant		Royal Management Corp.	**	526	526	23
24	V	10	Management allocation - salaries		Royal Management Corp.	**	25,518	25,518	24
25	V	15	Management allocation - employee benefits		Royal Management Corp.	**	2,728	2,728	25
26	V	17	Management allocation - salaries		Royal Management Corp.	**	21,695	21,695	26
27	V	19	Computer consultant & supplies		Royal Management Corp.	**	21,950	21,950	27
28	V	19	Professional fees		Royal Management Corp.	**	89,106	89,106	28
29	V	20	Dues & subscriptions		Royal Management Corp.	**	1,655	1,655	29
30	V	20	Advertising - help wanted		Royal Management Corp.	**	15,710	15,710	30
31	V	21	Management allocation - salaries		Royal Management Corp.	**	996,479	996,479	31
32	V	21	Bank charges		Royal Management Corp.	**	2,705	2,705	32
33	V	21	Office supplies & printing		Royal Management Corp.	**	9,203	9,203	33
34	V	21	Postage		Royal Management Corp.	**	4,557	4,557	34
35	V	21	Telephone		Royal Management Corp.	**	13,324	13,324	35
36	V								36
37	V								37
38	V		** The owners of Lexington Health Care Center of Lombard, Inc. ow						38
39	Total			$			$ 1,370,388	$ * 1,370,388	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	23	Inservice Training	$	Royal Management Corp.	**	$ 595	$ 595	15
16	V	24	Travel & seminar		Royal Management Corp.	**	772	772	16
17	V	25	Auto expense		Royal Management Corp.	**	17,146	17,146	17
18	V	26	Insurance general		Royal Management Corp.	**	3,104	3,104	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	108,830	108,830	19
20	V	30	Depreciation		Royal Management Corp.	**	25,741	25,741	20
21	V	32	Interest		Royal Management Corp.	**	15,938	15,938	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	2,388	2,388	22
23	V	33	Property taxes		Royal Management Corp.	**	6,847	6,847	23
24	V	34	Rent expense		Royal Management Corp.	**	4,661	4,661	24
25	V	35	Equipment rental		Royal Management Corp.	**	1,791	1,791	25
26	V	17	Management fees	1,532,340	Royal Management Corp.	**		(1,532,340)	26
27	V	35	Auto Lease		Royal Management Corp.	**	226	226	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		** The owners of Lexington Health Care Center of Lombard, Inc. ow						38
39	Total			$ 1,532,340			$ 188,039	$ * (1,344,301)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	James Samatas	33.33%	Lexington HC Ctr. of Bloomingdale, Inc.	Bloomingdale	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas	33.33%	Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem	33.34%	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Vesta Mgmt	Lombard	Mgmt. Company	3
4			Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Group, LLC			4
5			Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Lexington Square	Lombard	Independent and	5
6			Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Life Care of		Assisted Living	6
7			Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	Lombard, LLC		Facility	7
8			Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Lexington Square	Elmhurst	Independent	8
9			Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Life Care of		Living Facility	9
10					Elmhurst, LLC			10
11					Lexington Health	Lombard	Real Estate	11
12					Care Systems of		Property	12
13					Lombard Ltd. Pts			13
14					Royal Management	Lombard	Mgmt Company	14
15					Corporation			15
16					Lexington Financial	Lombard	Finance Company	16
17					Services, LLC			17
18					Heron Point	Lombard	Mgmt Company	18
19					Management Corp.			19
20					Samvest of	Lombard	Lessor	20
21					Lombard II, LLC			21
22					North Heron	Lombard	Finance Company	22
23					Investments, LLC			23
24					Lexington Home	Lombard	Home Health	24
25					Health Care, Inc.			25
26					Lexington Hospice	Lombard	Hospice	26
27					Services, LLC			27
28					Lexington Private	Lombard	Healthcare	28
29					Home Care			29
30					Merit Sleep Mgmt, LL	Lombard	Mgmt Company	30

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1					Sambell of	Bloomingdale	Real Estate	1
2					Bloomingdale Ltd. Pts		Property	2
3					Sambell of Chicago	Chicago Ridge	Real Estate	3
4					Ridge Ltd. Ptsp.		Property	4
5					Sambell of Elmhurst	Elmhurst	Real Estate	5
6					II Ltd. Ptsp.		Property	6
7					Sambell of LaGrange	LaGrange	Real Estate	7
8					Ltd. Ptsp.		Property	8
9					Lexington Health Care	Lake Zurich	Real Estate	9
10					Systems of Lake Zuric		Property	10
11					Ltd. Ptsp.			11
12					Lexington Health Care	Orland Park	Real Estate	12
13					Systems of Orland		Property	13
14					Park Ltd. Ptsp.			14
15					Sambell of	Schaumburg	Real Estate	15
16					Schaumburg Ltd. Ptsp		Property	16
17					Sambell of	Streamwood	Real Estate	17
18					Streamwood Ltd. Ptsp		Property	18
19					Lexington Health Care	Wheeling	Real Estate	19
20					Systems of Wheeling		Property	20
21					Ltd. Ptsp.			21
22					Samvest of Algonquin	Algonquin	Real Estate	22
23					Ltd. Ptsp.		Property	23
24					Curates,LLC	Lombard	Telemedicine	24
25					Republic Construction		Construction	25
26					of Illinois , Inc	Lombard	Company	26
27								27
28								28
29								29
30								30

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	0	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	$ 5,572	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops.	0	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	4,179	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	0	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,572	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	4,179	L17, C7	4
5	Phil Thiem	Executive Committee	Administrative	0	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	881	L17, C7	5
6	Jeremy Samatas	Executive Committee	Administrative	0	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	1,310	L17, C7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 21,693		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: ((630) 458-4700
Fax Number: ((630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	722,335	10	$ 2,704	$	81,760	$ 306	1
2	5	Utilities - gas & electric	Bed Days	722,335	10	70,024		81,760	7,926	2
3	5	Utilities - water & sewer	Bed Days	722,335	10	1,855		81,760	210	3
4	5	Utilities - maintenance office	Bed Days	722,335	10	5,025		81,760	569	4
5	6	Management allocation - salaries	Bed Days	722,335	10	1,178,292	1,178,292	81,760	133,369	5
6	6	Repairs & maintenance	Bed Days	722,335	10	72,883		81,760	8,250	6
7	6	Scavenger & exterminating	Bed Days	722,335	10	3,054		81,760	346	7
8	7	Management allocation - employee	Bed Days	722,335	10	125,945		81,760	14,256	8
9	10	Medical consultant	Bed Days	722,335	10	4,651		81,760	526	9
10	10	Management allocation - salaries	Bed Days	722,335	10	225,449	225,449	81,760	25,518	10
11	15	Management allocation - employee	Bed Days	722,335	10	24,098		81,760	2,728	11
12	17	Management allocation - salaries	Bed Days	722,335	10	191,670	191,670	81,760	21,695	12
13	19	Computer consultant & supplies	Bed Days	722,335	10	193,924		81,760	21,950	13
14	19	Professional fees	Bed Days	722,335	10	787,232		81,760	89,106	14
15	20	Dues & subscriptions	Bed Days	722,335	10	14,624		81,760	1,655	15
16	20	Advertising - help wanted	Bed Days	722,335	10	138,799		81,760	15,710	16
17	21	Management allocation - salaries	Bed Days	722,335	10	8,803,710	8,803,710	81,760	996,479	17
18	21	Bank charges	Bed Days	722,335	10	23,902		81,760	2,705	18
19	21	Office supplies & printing	Bed Days	722,335	10	81,306		81,760	9,203	19
20	21	Postage	Bed Days	722,335	10	40,262		81,760	4,557	20
21	21	Telephone	Bed Days	722,335	10	117,714		81,760	13,324	21
22										22
23										23
24										24
25	TOTALS					$ 12,107,123	$ 10,399,121		$ 1,370,388	25

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: ((630) 458-4700
Fax Number: ((630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	23	Inservice Training	Bed Days	722,335	10	$ 5,261	$	81,760	$ 595	1
2	24	Travel and Seminar	Bed Days	722,335	10	6,817		81,760	772	2
3	25	Auto expense	Bed Days	722,335	10	151,483		81,760	17,146	3
4	26	Insurance general	Bed Days	722,335	10	27,426		81,760	3,104	4
5	27	Management allocation - employee	Bed Days	722,335	10	961,496		81,760	108,830	5
6	30	Depreciation	Bed Days	722,335	10	227,415		81,760	25,741	6
7	32	Interest	Bed Days	722,335	10	140,807		81,760	15,938	7
8	32	Amortization of mortgage costs	Bed Days	722,335	10	21,094		81,760	2,388	8
9	33	Property taxes	Bed Days	722,335	10	60,494		81,760	6,847	9
10	34	Rent expense	Bed Days	722,335	10	41,178		81,760	4,661	10
11	35	Equipment rental	Bed Days	722,335	10	15,819		81,760	1,791	11
12	35	Auto Lease	Bed Days	722,335	10	1,993		81,760	226	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,661,283	$		$ 188,039	25

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Lexington Financial										$	1
2	Services, L.L.C.	X		Mortgage	Varies	2/20/2018	4,540,000		2/19/2020	Libor + 3.5%	65,212	2
3	Midcap Financial Trust		X	Mortgage	Varies	5/29/2018	5,803,182	5,803,182	5/29/2021	Libor + 5.25%	259,349	3
4												4
5								Finance Charge - Insurance Policy			2,297	5
	Working Capital											
6	See Sch. 9A										(2,297)	6
7	Shareholder Loan	X		Capital Improvements	Varies	7/16/2008	499,000	513,953	Demand	Prime	24,489	7
8	Shareholder Loan	X		Working Capital	Varies	4/30/2008	2,230,000	2,230,000	Demand	Prime	109,438	8
9	TOTAL Facility Related						$ 13,072,182	$ 8,547,135			$ 458,487	9
	B. Non-Facility Related*											
10								Interest Income Offset			(279,308)	10
11								Offset of Shareholder Interest			(133,927)	11
12								Allocated from Mgmt Co.			18,326	12
13								Amortization of Mortgage Costs			57,494	13
14	TOTAL Non-Facility Related						$	$			$ (337,415)	14
15	TOTALS (line 9+line14)						$ 13,072,182	$ 8,547,135			$ 121,072	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name: Lexington Health Care Center of Lombard
IDPH License ID Number: 0028860
Fiscal Year End: 12/31/18

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		X	Line of Credit	Varies	4/30/2012	2,500,000		10/31/2018	Prime/Libor		6
7												7
8												8
9	TOTAL Facility Related				$0.00		$ 2,500,000	$ 0			$ 0	9
	B. Non-Facility Related*											
10								Non-Allowable Finance Charge			(2,297)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$0.00		$ 0	$ 0			$ (2,297)	14

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 214,900	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2017	$ 201,157	2
3. Under or (over) accrual (line 2 minus line 1).		$ (13,743)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 207,192	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
	Alloc Fr. Mgmt Co.	6,847	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 200,296	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	187,527	8
	2014	206,048	9
	2015	186,772	10
	2016	196,570	11
	2017	201,157	12

See attached real estate accrual sheet

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center of Lombard, Inc. COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0028660

CONTACT PERSON REGARDING THIS REPORT Karen Gillis

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-19-307-002	Land & Building	$ 201,157.06	$ 201,157.06
2.	Royal Management Corp. (Samvest of Lombard II)		$ 253,394.82	$ 6,847.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 454,551.88	$ 208,004.06

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 78770 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Lexington Square Life Care of Lombard, LLC : Retirement Community; 273 units; 309,000 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	30,000	1984	$ 616,761	1
2	Management Company Allocation			20,613	2
3	TOTALS	30,000		$ 637,374	3

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	215		1984	1984	$ 3,661,472	$ -	35	$ 104,614	$ 104,614	$ 3,580,833	4
5	9		1995	1995	284,156	8,119	35	8,119		182,673	5
6						-		-			6
7						-		-			7
8						-		-			8
	Improvement Type**										
9	Building Improvements			1990	96,219	-	10	-		96,218	9
10	Leasehold Improvements Additions			1995	71,493	-	10	-		71,493	10
11	Building Improvements			1994	20,200	-	10	-		20,200	11
12	Building Improvements			1995	14,535	415	35	415		9,756	12
13	Building Improvements - dishwater hood			1996	2,748	-	10	-		2,748	13
14	Building Improvements - outside painting			1996	11,308	-	10	-		11,308	14
15	Building Improvements - dining room			1996	3,752	-	10	-		3,752	15
16	Leasehold Improvements			1992	16,299	466	35	466		12,345	16
17	Leasehold Improvements			1994	21,836	-	10	-		21,836	17
18	Leasehold Improvements - 2nd floor			1996	19,319	-	10	-		18,353	18
19	Leasehold Improvements - bathroom rehab			1996	9,216	-	10	-		8,909	19
20	Leasehold Improvements - fan coil repairs			1996	6,669	191	35	191		4,261	20
21	Land Improvements			1993	2,985	-	15	-		2,985	21
22	Land Improvements			1995	4,596	-	15	-		4,595	22
23	Capitalized Repairs			1986	1,730	-	10	-		1,730	23
24	Building Improvements - basement			1996	18,993	-	10	-		18,993	24
25	Leasehold Improvements - Corner Guards			1997	520	-	10	-		520	25
26	Leasehold Improvements - Corridor flooring			1997	10,380	-	10	-		10,380	26
27	BI: Kitchen Rehab			1998	2,494	-	10	-		2,494	27
28	Wiring for MDS project			1998	3,365	-	10	-		3,365	28
29	Install Fire Sprinklers in Mechanical Rms			1998	4,600	131	35	131		2,690	29
30	Tile for Lobby			1998	20,530	-	10	-		20,530	30
31	Walk in Freezers/Coolers			1998	3,183	91	35	91		1,865	31
32	Fire Wall Repairs			1998	12,411	355	35	355		7,274	32
33	Underground storage tank			1998	2,613	-	10	-		2,613	33
34	Repave parking lot			1999	7,625	-	15	-		7,625	34
35	Lounge Floor Tile			1999	2,963		10			2,963	35
36						-		-			36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Rewire Building	1999	$ 9,083	$ 260	35	$ 260	$	$ 5,066	37
38	Heat exchanger for water heater	1999	1,660	-	5	-		1,660	38
39	Compressor and tank for freezer	1999	2,924	-	5	-		2,924	39
40	Plumbing Improvements	2000	2,833	-	10	-		2,833	40
41	Relocate 2nd floor sprinklers	2000	2,200	63	35	63		1,164	41
42	Water heater repairs	2000	3,831	-	5	-		3,831	42
43	Automatic door	2000	4,556	130	35	130		2,409	43
44	Install sprinklers	2001	6,082	-	10	-		6,082	44
45	Infrared curtains for elevator	2001	4,500	-	10	-		4,500	45
46	Elevator upgrade	2002	3,006	-	5	-		3,006	46
47	Condensor	2002	2,679	-	5	-		2,679	47
48	Resurfacing Parking Lot	2003	30,690	1,535	20	1,535		23,662	48
49	Plumbing loop repairs	2003	6,125	-	10	-		6,125	49
50	Fire alarm panel/call system	2003	8,495	425	20	425		6,763	50
51	Facility Rehab - Painting	2003	6,872	-	10	-		6,872	51
52	Facility Rehab - Floor Tile	2003	28,888	1,444	20	1,444		22,076	52
53	Nurse call system	2003	49,451	2,473	20	2,473		37,299	53
54	Brick paved sidewalk/entryway	2003	5,855	293	20	293		4,516	54
55	Facility redecorating - painting/wallpaper	2003	314,478	15,724	20	15,724		251,584	55
56	Fire alarm panel/call system	2003	276,327	13,816	20	13,816		221,058	56
57	Floor Tile	2003	58,720	2,936	20	2,936		46,976	57
58	Carpeting/cove base	2003	29,518	-	10	-		29,518	58
59	Water heater	2004	9,209	-	10	-		9,209	59
60	Kitchen sewer and dishroom	2004	31,233	1,562	20	1,562		21,997	60
61	Landscaping	2005	3,255	163	20	163		2,186	61
62	HVAC	2005	8,028	401	20	401		5,281	62
63	Kitchen sewer, dishroom and ceiling	2005	22,924	1,146	20	1,146		15,567	63
64	Lobby and reception redecorating - painting/wallpaper	2005	37,999	1,900	20	1,900		25,967	64
65	Rehab therapy room - electrical, carpet, tile	2005	66,393	3,320	20	3,320		45,372	65
66	Rehab 1st floor therapy room - electrical, carpet, tile	2005	39,341	1,967	20	1,967		26,882	66
67	Wallpaper, tile, electrical for transitional unit	2005	22,946	1,147	20	1,147		15,772	67
68	Window treatments	2005	8,053	403	20	403		5,473	68
69	Tile, flooring, and wallpaper	2005	57,699	2,885	20	2,885		39,188	69
70	TOTAL (lines 4 thru 69)		$ 5,504,063	$ 63,761		$ 168,375	$ 104,614	$ 5,040,804	70

**Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,504,063	$ 63,761		$ 168,375	$ 104,614	$ 5,040,804	1
2	Countertops	2005	845	-	5	-		845	2
3	Curtains and blinders	2005	4,672	-	5	-		4,672	3
4	Mini scroll	2005	527	-	5	-		527	4
5	Medical Records Storage/Office Room	2006	5,901	148	40	148		1,800	5
6	Office Remodel	2006	5,537	138	40	138		1,656	6
7	Piping	2006	4,511	301	15	301		3,712	7
8	HVAC	2006	7,985	200	40	200		2,400	8
9	Emergency A/C	2006	9,385	235	40	235		2,820	9
10	Adm Office-HVAC	2006	6,421	161	40	161		1,998	10
11	Sink installation	2006	2,561	64	40	64		816	11
12	Land Improvements Patio	2006	23,736	1,582	15	1,582		19,512	12
13	Brick Pavers	2007	8,500	567	15	567		6,615	13
14	Landscaping	2007	16,420	821	20	821		9,373	14
15	Parking Lot	2007	13,219	661	20	661		7,546	15
16	Roof	2007	9,800	490	20	490		5,758	16
17	HVAC	2007	8,197	410	20	410		4,715	17
18	LHI-Emergency A/C	2007	11,126	556	20	556		6,209	18
19	LHI-Plumbing & Sprinkler	2007	6,799	509	10		(509)	6,799	19
20	Automatic Doors is Common Areas	2007	20,874	1,044	20	1,044		11,919	20
21	Tike System & Foundation	2007	4,500	225	20	225		2,494	21
22	Exterior of Building Painting	2007	16,600	830	20	830		9,338	22
23	Landscaping	2008	21,600	1,440	15	1,440		15,480	23
24	Parking Lot	2008	9,625	481	20	481		5,091	24
25	Roof Repair	2008	11,001	550	20	550		5,683	25
26	HVAC	2008	20,164	1,102	20	1,102		11,565	26
27	Sink and Toliet	2008	4,000	400	10	133	(267)	4,000	27
28	Elevator Upgrades	2008	171,955	4,299	40	4,299		44,065	28
29	Metal Doors	2008	3,907	195	20	195		2,097	29
30	Basement Renovation	2008	25,195	1,260	20	1,260		13,440	30
31	Trash Compactor	2008	11,590	580	20	580		6,090	31
32	Painting Gazebo	2008	4,450	223	20	223		2,322	32
33				-		-			33
34	TOTAL (lines 1 thru 33)		$ 5,975,666	$ 83,233		$ 187,071	$ 103,838	$ 5,262,161	34

**Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,975,666	$ 83,233		$ 187,071	$ 103,838	$ 5,262,161	1
2	2nd floor remodel-Electric, flooring,painting	2008	561,165	-	27	20,406	20,406	205,761	2
3	Kitchen Upgrade-Carpentry, painting, plumbing	2008	18,364	-	27	668	668	6,736	3
4	1st floor remodel-painting, electrical, flooring,plumbing	2008	547,836	-	27	19,921	19,921	217,471	4
5	Irrigation System	2009	14,235	949	15	949		8,936	5
6	Landscaping Enhancements	2009	22,005	1,467	15	1,467		13,937	6
7	Roof	2009	139,578	6,979	20	6,979		65,719	7
8	Fan Coil	2009	5,607	280	20	280		2,731	8
9	Quick Connectors	2009	5,300	265	20	265		2,562	9
10	Room Convector	2009	4,962	248	20	248		2,294	10
11	Nurse Call System	2009	35,509	1,291	27	1,291		12,046	11
12	Electrical key pad	2009	5,995	218	27	218		2,053	12
13	PT Room Countertops	2009	4,050	147	27	147		1,336	13
14	2nd floor remodel-Electric, flooring,painting	2009	2,935	107	27	107		1,052	14
15	Patio Pergola	2009	10,849	542	20	542		4,969	15
16	Landscaping/Retaining wall	2010	4,741	316	15	316		2,686	16
17	Ejector Pump	2010	6,983	466	15	466		3,960	17
18	Parking lot repair/signs	2010	8,970	533	15	533		5,804	18
19	Repair Roof	2010	24,000	1,200	20	1,200		9,700	19
20	Key pad entrance	2010	3,085	308	10	308		2,696	20
21	Canopy	2010	2,567	257	10	257		2,205	21
22	Exhaust HVAC	2010	4,003	146	27	146		1,192	22
23	Drainline	2010	4,130	151	27	151		1,220	23
24	Pantry carpentry,electrical,plumbing	2010	7,566	276	27	276		2,323	24
25	Paint over bed lights	2010	6,319	231	27	231		2,001	25
26	Library/Lounge carpentry,painting,signs	2010	8,441	308	27	308		2,567	26
27	Second floor doors	2010	3,144	314	10	314		2,748	27
28	Med Room carpentry,plumbing	2010	7,678	280	27	280		2,357	28
29	Patio Pergola	2010	11,695	-	5	-		11,695	29
30	Stamped concrete	2010	15,862	1,057	15	1,057		9,161	30
31	Office carpentry,flooring,electrical,painting,plumbing,signs	2010	64,446	1,793	27	1,793		36,040	31
32	3rd floor remodel-carpentry,plumbing,electrical,painting	2010	753,399	-	27	60,085	60,085	515,729	32
33				-		-			33
34	TOTAL (lines 1 thru 33)		$ 8,291,085	$ 103,362		$ 308,280	$ 204,918	$ 6,423,848	34

**Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 8,291,085	$ 103,362		$ 308,280	$ 204,918	$ 6,423,848	1
2				-		-			2
3	Office Remodel - carpentry,plumbing,electrical,painting	2011	11,187	407	27	407		3,120	3
4	Front Entrance remodel of kitchen doors	2011	3,584	130	27	130		910	4
5	Remodel Shower Room - Carpentry, Flooring, Electrical,	2011	53,886	1,959	27	1,959		14,203	5
6	-Plumbing, Showers, Millwork & Painting			-		-			6
7	Boiler Coll HVAC	2011	3,175	115	27	115		864	7
8	Roof Top Unit HVAC	2011	40,890	1,487	27	1,487		10,781	8
9	Fire Dampers HVAC	2011	67,012	2,437	27	2,437		17,262	9
10	Remodel Laundry Room - Electrical, Painting and Flooring	2011	9,814	357	27	357		2,648	10
11	Replace Doors on 1st Floor	2011	57,237	2,081	27	2,081		14,740	11
12	Replace doors on 2nd Floor	2011	39,952	1,453	27	1,453		10,655	12
13	Doctors office-keys, painting, flooring	2012	5,484	199	27	199		813	13
14	Generator Exhaust	2012	21,590	785	27	785		5,233	14
15	Sprinklers in building - Front Canopy & Lobby Area	2012	11,558	420	27	420		2,590	15
16	Replace sanitary pipe	2012	5,800	211	27	211		1,389	16
17	Replace lights, mirrors in 1st floor resident rooms	2012	10,962	399	27	399		2,593	17
18	Replacement faucets in 1st floor resident rooms	2012	6,410	233	27	233		1,495	18
19	EMR Wiring- Entire Facility	2012	18,690	680	27	680		4,193	19
20				-		-			20
21	Fence- Entire Facility	2013	5,840	389	15	389		2,010	21
22	Sprinkler Heads- Entire Facility	2013	25,361	922	27	922		5,225	22
23	Holding Tank- Kitchen	2013	25,724	935	27	935		4,675	23
24				-		-			24
25	R/M Reclass: Generator transfer switch in Mechanical Room	2014	4,681	-	12	390	390	1,755	25
26	R/M Reclass: Landscaping for flowers around main entrance	2014	2,840	-	15	189	189	852	26
27				-		-			27
28	Add EMR Wiring 1st floor	2015	5,268	192	27	192		687	28
29	Replaced four boilers in boiler room	2015	173,357	6,304	27	6,304		19,437	29
30	R/M Reclass: Sealcoating and paving parking lot	2015	4,200	-	20	210	210	735	30
31				-		-			31
32				-		-			32
33				-		-			33
34	TOTAL (lines 1 thru 33)		$ 8,905,588	$ 125,457		$ 331,164	$ 205,707	$ 6,552,713	34

**Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 8,905,588	$ 125,457		$ 331,164	$ 205,707	$ 6,552,713	1
2				-		-			2
3	Chair Rail Installation in First and Second Floor Rooms	2016	10,199	378	27	378		754	3
4	R&M Reclass: Doors Installation on: 2nd and 3rd Floors North Si	2016	5,786	-	10	579	579	1,447	4
5	and South Side Shower Entrances			-		-			5
6	R/M Reclass: Underground Sanitary Pipe Replacement in the Low	2016	2,500	-	15	167	167	417	6
7	Level Entrance to Ramp Area and Back Elevator Hallway			-		-			7
8	R/M Reclass: Fire Pump Overhaul and New Gauge Tap and Gaug	2016	4,495	-	15	300	300	750	8
9	Installation in the Fire Pump Room in the Basement			-		-			9
10				-		-			10
11				-		-			11
12						-			12
13	Reconcile to book			(621)		-	621		13
14				-		-			14
15				-		-			15
16				-		-			16
17				-		-			17
18				-		-			18
19				-		-			19
20				-		-			20
21				-		-			21
22				-		-			22
23				-		-			23
24				-		-			24
25				-		-			25
26				-		-			26
27				-		-			27
28				-		-			28
29				-		-			29
30				-		-			30
31				-		-			31
32				-		-			32
33				-		-			33
34	TOTAL (lines 1 thru 33)		$ 8,928,568	$ 125,214		$ 332,588	$ 207,374	$ 6,556,081	34

**Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 8,928,568	$ 125,214		$ 332,588	$ 207,374	$ 6,556,081	1
2				-		-			2
3	Building-management company	2002	285,241	-	40	6,453	6,453	139,381	3
4	HVAC, electrical, security system-management company	2003	2,505	-	30	224	224	2,142	4
5	Key card system-management company	2004	394	-	20	20	20	284	5
6	VAV TX controls-management compnay	2005	120	-	20	6	6	83	6
7	Building Improvements-Management Company	2006	87	-	20	6	6	71	7
8	Building Improvements-Management Company	2008	12,610	-	20	155	155	5,707	8
9	Building Improvements-Management Company	2009	2,405	-	20	135	135	1,246	9
10	Building Improvements-Management Company	2010	2,359	-	20	103	103	1,133	10
11	Building Improvements-Management Company	2011	1,774	-	20	85	85	620	11
12	Building Improvements-Management Company	2012	5,577	-	20	211	211	1,366	12
13	Building Improvements-Management Company	2013	4,634	-	20	274	274	1,709	13
14	Building Improvements-Management Company	2014	2,508	-	20	256	256	1,131	14
15	Building Improvements-Management Company	2015	441	-	20	55	55	189	15
16	Building Improvements-Management Company	2016	7,277	-	20	552	552	1,290	16
17	Building Improvements-Management Company	2017	4,654	-	20	206	206	288	17
18	Building Improvements-Management Company	2018	883	-	20	19	19	19	18
19				-					19
20				-					20
21				-					21
22				-					22
23				-					23
24				-					24
25				-					25
26				-					26
27				-					27
28				-					28
29				-					29
30				-					30
31				-					31
32				-					32
33				-					33
34	TOTAL (lines 1 thru 33)		$ 9,262,037	$ 125,214		$ 341,349	$ 216,135	$ 6,712,740	34

**Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 685,516	$ 24,509	$ 44,502	$ 19,993	5--10	$ 259,833	71
72	Current Year Purchases	14,650	1,053	1,053	-	5	1,053	72
73	Fully Depreciated Assets	1,214,213			-	5--7	1,214,213	73
74	Allocated from Mgmt. Co.	547,684		15,026	15,026	5--7	501,760	74
75	TOTALS	$ 2,462,062	$ 25,562	$ 60,581	$ 35,019		$ 1,976,859	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$ -	$ -	$ -		$	76
77					-	-	-			77
78					-	-	-			78
79	Allocated from Mgmt. Co.			51,837	-	1,954	1,954	5	46,876	79
80	TOTALS			$ 51,837	$	$ 1,954	$ 1,954		$ 46,876	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	12,413,310	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	150,776	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	403,884	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	253,108	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	8,736,475	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Management Compar				4,661			6
7	TOTAL				$ 4,661 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 58,229 Description: Copier: $8,890, Postage: $523, Med Equip: $14,701, Oxygen: $32,324, Mgmt Alloc.: $1,791
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20	Allocated from Management Company			226	20
21	TOTAL		$	$ 226	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	$	5,983	$ 347,376	$	5,983	$ 347,376	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,611	110,122		3,611	110,122	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		9,778	478,835		9,778	478,835	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				196,130		196,130	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)				(5,511)			(5,511)	12
13	Other (specify): See Sch 16A	39(2)					8,861		8,861	13
14	TOTAL			$	19,372	$ 930,822	$ 204,991	19,372	$ 1,135,813	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name: **Lexington Health Care Center of Lombard**
IDPH License ID Number: **0028860**
Fiscal Year End: **12/31/18**

Schedule 16A

Line 13 Other (specify)

Description	Units	Amount
Oxygen	39(2)	5,040
DME	39(2)	126
Rehab Supplies	39(2)	3,695
Total - Line 13		**8,861**

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 **Report Period Beginning:** 1/1/18 **Ending:** 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/18 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 593,915	$ 1,738,653	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (2,172,238))	2,392,336	2,392,336	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	295,604	295,604	6
7	Other Prepaid Expenses	37,819	37,819	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch 17A	279,895	4,703,858	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,599,569	$ 9,168,270	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		637,374	13
14	Buildings, at Historical Cost		3,661,472	14
15	Leasehold Improvements, at Historical Cost	3,083,301	5,600,565	15
16	Equipment, at Historical Cost	533,013	2,513,899	16
17	Accumulated Depreciation (book methods)	(2,221,200)	(8,736,475)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp See Sch 17A	1,257,439	1,257,439	22
23	Other(specify): Mortgage cost		167,287	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,652,553	$ 5,101,561	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,252,122	$ 14,269,831	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 568,138	$ 568,138	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	460,592	460,592	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,685	24,685	31
32	Accrued Real Estate Taxes(Sch.IX-B)		207,192	32
33	Accrued Interest Payable		104,798	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	4,602,396	1,191,874	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,655,811	$ 2,557,279	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	513,953	2,743,953	39
40	Mortgage Payable		5,803,182	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 513,953	$ 8,547,135	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,169,764	$ 11,104,414	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 82,358	$ 3,165,417	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,252,122	$ 14,269,831	48

***(See instructions.)**

Facility Name: **Lexington Health Care Center of Lombard**
IDPH License ID Number: **0028860**
Fiscal Year End: **12/31/18**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

	Description	Operating	After Consolidation
00-13703-00	Due from Royal - Loan Receivable	-	669,548
00-13712-00	Due From/(to) Lhcc Streamwood	-	2,252,239
00-13714-00	Due From/(to) Lhcc Bloomingdale	-	4,325
00-13715-00	Due From/(to) Lhcc Schaumburg	-	603,926
00-13716-00	Due To/from Egm	-	893,925
00-23730-00	Due to Bloomingdale	149,949	149,949
00-23810-00	Due to Streamwood	129,946	129,946
	Total - Line 9	**279,895**	**4,703,858**

XV. Balance Sheet
Line 22 Long-Term Assets Other (specify): - -

	Description	Operating	After Consolidation
00-13040-00			
00-18000-00	Receivable From Insurance Recoveries	1,257,439	1,257,439
	Total - Line 22	**1,257,439**	**1,257,439**

XV. Balance Sheet - -
Line 36 Other Current Liabilities (specify):

Account No	Description	Operating	After Consolidation
00-10140-00	Cash Patient Trust	18,983	18,983
00-12020-00	Pa Audit Settlement	36,238	36,238
00-13040-00	Rent Receivable	-	(3,224,985)
00-13200-00	Due From -vesta	(131)	(131)
00-13240-00	Due To Lex Fin Svcs I	-	-
00-13710-00	Due From/(to) Lhcc Lombard	-	(185,537)
00-14530-00	Prepaid Insurance	52,118	52,118
00-21030-00	Cobra	1,895	1,895
00-21040-00	Withholding - Dental Insurance	(2,247)	(2,247)
00-21050-00	Withholding - Ep/ci/wl	(1,874)	(1,874)
00-21085-00	Vision Withholding	(642)	(642)
00-21095-00	Fsa/hsa Withholdings-	145	145
00-21100-00	401k Withholding	(882)	(882)
00-22030-00	Accrued Expenses	57,059	57,059
00-22040-00	Accrued Resident Tax	-	-
00-22060-00	Accrued Vesta 3% Management Fees	10,511	10,511
00-22065-00	Accrued Royal Management Fees	(74,630)	(74,630)
00-22120-00	Accrued Rent	3,224,985	3,224,985
00-22140-00	Accrued Insurance	139,566	139,566
00-22270-00	Due To Patient Trust Fund	(15,741)	(15,741)
00-22330-00	Advance - Biweekly Part A Paym	65,010	65,010
00-22360-00	Uncollectible Part A Co Pvts	-	-
00-23530-00	Due To - Royal Operations	16,409	16,409
00-23720-00	Due To/from Republic Construction	5,503	5,503
00-23740-00	Due To Chicago Ridge	-	-
00-23750-00	Due To Lhcc Elmhurst	-	-
00-23760-00	Due To Lagrange	-	-
00-23780-00	Due To/from Lhc System Of Lombard	185,537	185,537
00-23790-00	Due To Orland Park	90	90
00-23800-00	Due To Schaumburg	(119,936)	(119,936)
00-23830-00	Due/to From Square Lombard	(332,763)	(332,763)
00-24400-00	Professional Liabilities Claims	1,353,855	1,353,855
00-21260-00	Due from Ins carrier	(16,662)	(16,662)
	Total - Line 36	**4,602,396**	**1,191,874**

- -

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 **Report Period Beginning:** 1/1/18 **Ending:** 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 584,716	1
2	Restatements (describe):		2
3	**Post Closing Adjustment**	(512,509)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 72,207	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	10,151	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 10,151	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 82,358	24 *

*** This must agree with page 17, line 47.**

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 18,935,289	1
2	Discounts and Allowances for all Levels	(8,429,428)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,505,861	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,008,511	6
7	Oxygen	12,108	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,020,619	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	15,704	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	294,528	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	102,493	19
20	Radiology and X-Ray	9,807	20
21	Other Medical Services	173,573	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 596,105	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,649	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,649	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other income	41	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 41	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,142,275	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,789,639	31
32	Health Care	5,746,865	32
33	General Administration	3,700,384	33
	B. Capital Expense		
34	Ownership	963,135	34
	C. Ancillary Expense		
35	Special Cost Centers	1,522,123	35
36	Provider Participation Fee	409,978	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,132,124	40
41	**Income before Income Taxes (line 30 minus line 40)****	10,151	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 10,151	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,769,939	44
45	Private Pay - Net Inpatient Revenue	1,590,130	45
46	Medicare - Net Inpatient Revenue	(634,426)	46
47	Other-(specify) Managed Care	188,720	47
48	Other-(specify) Life Care	591,498	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,505,861	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No^ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

^ Entity is a cash basis taxpayer

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	-	2,437	$ 153,970	$ 63.17	1
2	Assistant Director of Nursing	2,010	2,380	101,483	42.64	2
3	Registered Nurses	38,110	46,008	1,577,505	34.29	3
4	Licensed Practical Nurses	20,328	24,716	674,981	27.31	4
5	CNAs & Orderlies	79,606	92,144	1,408,114	15.28	5
6	CNA Trainees	-	-	-		6
7	Licensed Therapist	-	-	-		7
8	Rehab/Therapy Aides	-	-	-		8
9	Activity Director	1,720	2,064	42,767	20.72	9
10	Activity Assistants	7,944	9,570	141,343	14.77	10
11	Social Service Workers	7,530	8,834	187,995	21.28	11
12	Dietician	2,032	2,168	62,912	29.02	12
13	Food Service Supervisor	1,851	2,098	61,060	29.10	13
14	Head Cook	157	493	8,999	18.27	14
15	Cook Helpers/Assistants	21,519	24,126	292,643	12.13	15
16	Dishwashers	-	-	-		16
17	Maintenance Workers	1,781	2,133	43,261	20.28	17
18	Housekeepers	30,887	37,292	444,779	11.93	18
19	Laundry	-	-	-		19
20	Administrator	1,556	1,915	157,731	82.38	20
21	Assistant Administrator	-	-	-		21
22	Other Administrative	-	-	-		22
23	Office Manager	-	-	-		23
24	Clerical	7,564	9,304	198,646	21.35	24
25	Vocational Instruction	-	-	-		25
26	Academic Instruction	-	-	-		26
27	Medical Director	-	-	-		27
28	Qualified MR Prof. (QMRP)	-	-	-		28
29	Resident Services Coordinator	-	-	-		29
30	Habilitation Aides (DD Homes)	-	-	-		30
31	Medical Records	145	181	3,720	20.61	31
32	Other Health C: See Sch 20A	14,983	18,052	458,707	25.41	32
33	Other(specify) Marketing	8	(360)	(16,145)	44.81	33
34	TOTAL (lines 1 - 33)	239,732	285,553	$ 6,004,470 *	$ 21.03	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	48,550	9(3)	36
37	Medical Records Consultant	Monthly	293	10(3)	37
38	Nurse Consultant	Monthly	6,525	10(3)	38
39	Pharmacist Consultant	Monthly	16,490	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	24,490	10(3)	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,376	11(3)	44
45	Social Service Consultant	Monthly	4,320	12(3)	45
46	Other(specify) Pulmonary	Monthly	24,490	10(3)	46
47	Post Acute Consultant	Monthly	4,009	10(3)	47
48	Telemedicine Consultant	Monthly	9,150	10(3)	48
49	TOTAL (lines 35 - 48)		$ 140,693		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	149	$ 8,857	10(3)	50
51	Licensed Practical Nurses	897	40,437	10(3)	51
52	Certified Nurse Assistants/Aides	18,302	491,579	10(3)	52
53	TOTAL (lines 50 - 52)	19,348	$ 540,873		53

Facility Name: **Lexington Health Care Center of Lombard**
IDPH License ID Number: **0028860**
Fiscal Year End: **12/31/18**

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Accounts Coordinator	2,509	3,106	40,562	13
Admissions	2,438	3,028	61,762	20
Clinical Coordinator	2,493	2,945	92,106	31
MDS	2,819	3,303	129,465	39
Staffing Coordinator	2,346	2,871	46,376	16
Unit Secretary	1,484	1,773	43,192	24
Wound Care Coordinator	893	1,027	45,245	44
Total - Line 32 Other Health Care (specify):	**14,983**	**18,052**	**458,707**	

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jennifer Miller	Administrator	0	$ 157,731
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 157,731

B. Administrative - Other

Description	Amount
Shared Services	$ 676,248
Management Fees-Royal Operatns	856,092
Eliminated in Column 7	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,532,340
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RSM US LLP	Accounting	$ 35,902
Royal Management Operation	Consulting	932
Personnel Planners Inc	U/C Consulting	1,890
Midcap Financial	Financial	3,627
Much Shelist	Legal	13,624
Duane Morris	Legal	874
Secretary of State	Legal	125
Hinshaw & Culbertson	Legal	234
Huges socol Piers	Legal	942
Bert Spliker & Associates	Legal	76
See Sch 21C		153,057
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 211,283

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 106,629
Unemployment Compensation Insurance	42,665
FICA Taxes	446,932
Employee Health Insurance	257,908
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	12,688
Other Employee Benefits	25,113
Uniform Allowance	770
TOTAL (agree to Schedule V, line 22, col.8)	$ 892,705

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	6,585
Health Care Worker Background Check	
(Indicate # of checks performed 112)	1,343
Patient Background Checks 471	5,653
Miscellaneous Licenses & Fess	1,532
Miscellaneous Dues & Subscriptions	1,254
Less: Non-Allowable Dues	(2,673)
Management Company Allocation	17,365
IHCA	5,346
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,395

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Allocated from Management	772
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 772

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Lexington Health Care Center of Lombard**
IDPH License ID Number: **0028860**
Fiscal Year End: **12/31/18**

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Midcap Financial	Legal	2,530
Various	Collections	37,568
Lexington Financial Services	LLC & 401k audit	818
Connected For Care Ll	Computer Services	9,404
Lawson	Computer Services	12,080
Network Infrastructure	Computer Services	833
Relias	Computer Services	7,525
Onshift	Computer Services	7,222
Icims	Computer Services	3,477
Info Controls	Computer Services	2,851
Sales Force	Computer Services	10,627
National Datacare Corp.	Computer Services	1,454
Computer Software	Computer Services	17,033
Computer Services - Prof Services	Computer Services	3,399
Softchoice	Computer Services	2,187
Hardware Support	Computer Services	68
Touch Point	Computer Services	2,553
Microsoft	Computer Services	12,972
Healthmedx	Computer Services	3,497
Netsmart	Computer Services	10,267
Gp Software	Computer Services	4,691
	Total (agree to Schedule V, line 19, column 3)	211,283.00
Less: Non-Allowable Legal Fees		(37,665)
Allocated from Management Company	Professional Services	200
		173,818
Allocated from Mgmt Co.		
Much Shelist	Legal	1,670
Duane Morris	Legal	1,069
Partridge Partners	Legal	81
RSM	Accounting	1,834
Friedman & Huey	Accounting	552
IL Secretary of State	Filing Fees	6
West Suburban Bank	Banking	6
Personnel Planners	U/C Consultant	11
LaSalle Network	Recruiting / Finance	9,688
Pension Administrators, Inc.	401K Administration	252
Gene Whitehorn	Public Aid Pending Consultant	1,669
Steely Group LLC	Financial Consulting	2,723
M Werner Consulting	Public Aid Consultant	75
Early Stage Solutions	Financial Consulting	18,467
Objective Arts	Public Aid Pending Consultants	338
Adam Lefton	Financial Consulting	7,832
Brilliant Staffing LLC	Financial Consulting	2,603
Mark J Eenigenburg	Budgeting Consultant	2,437
Deloitte Consulting LLP	Compensation Consulting	1,142
John Mattone Partners	Workplace Consultant	6,297
Mark Rodeghier	Survey Preparation Consultant	337
JGC Advisors LLC	Contracting Consultant	158
Michel Desjardins	Contracting Consultant	85
Pathway Health Services	Operational & Financial Consulting	(180)
Brandlin & Associates	Banking Consultants	24,292
Steven Wood	Strategy/Operations Consulting	958
Susan Parker	Social Service Consultant	16
Focus Pointe Global	Strategic Planning	265
Andrzej Stankiewicz	General Business Consulting	222
DLC	Financial Planning & Analysis	3,559
Fieldwork	Recruitment Consultant	476
Computer Services	Computer Consulting	21,950
		110,889
Allocated from SV of Lombard II		
Friedman & Huey	Accounting	138
Duane Morris	Legal	26
Illinois Secretary of State	Filing Fees	3
		167
	Total (agree to Schedule V, line 19, column 8)	**284,874**

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Lombard # 0028860 **Report Period Beginning:** 1/1/18 **Ending:** 12/31/18

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $5346**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **48,894** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **409,978**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **RSM US LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.